Washington Medicaid Integration Project (WMIP)
Community Advisory Board

Meeting Summary
September 2, 2004

Facilitator: **Janelle Sgrignoli**

A regular meeting of the WMIP Community Advisory Board was held on Thursday, September 2, 2004 from 10:30 AM – 12:30 PM at the Snohomish County Human Services Department, 2722 Colby, 1st Floor NW Conference Room, and Everett Washington.

ATTENDANCE

COMMUNITY ADVISORY BOARD MEMERSHIP

Steve Ahern	Snohomish County Council on Aging
Chuck Benjamin	NSMHA
Randall Downey	SEIU 775
Jack Eckrem	Alcohol and Other Drugs Advisory Board
Marie Jubie	NSMHA
Mike Manley	Snohomish County Human Services
Steve Reinig	Compass Health
Janelle Sgrignoli	Snohomish County Human Services
Ann Vining	NW Justice Project
Gerald Yorioka, MD	Snohomish County medical Society

COMMUNITY ADVISORY BOARD NON-VOTING MEMBERS

Randy Burge	DSHS DDD
Frank Busichio	Snohomish Health District
LaRonda Durrant	The Everett Clinic
Ann Koontz	Molina
Eleanor Owen	MH Citizen Advocate
Terry Marker	HCS DSHS
Peggy Wanta	Molina Healthcare

GUESTS

Cammy Hart-Anderson	Snohomish County Human Services – AOD
Cathy Cochran	DSHS
Lorraine Cronk	Snohomish County Council on Aging
Jerry Fireman	Snohomish County Human Services LTC&A
Chris Imhoff	DSHS – MHD
Nancy Jones	Snohomish County Human Services - MH
Mary King	Snohomish County Human Services LTC&A
Kristi Knudsen	DSHS – ADSA
Alice Lind	DSHS-MAA
Brett Lawtin	DSHS - MAA
Mary Anne Lindelslul	DSHS – MAA
Becky McAninch-Dake	DSHS – MAA
David Mancose	DSHS-RDA
Carey Morris	Snohomish County Council - Lobbyist
Bill Moss	ADSA/DSHS
Dan Murphy	DSHS - ADSA
Harvey Perez	DSHS-DASA
Deidre Ridgway	NSMHA
Stuart Torgerson	Snohomish County Human Services - DD
Bo Tunestam	Snohomish County Human Services

Note:
Errors/omissions in verbatim transcription are due to
noise interference and were not editing judgments by the scribe.

WELCOME & INTRODUCTIONS
Introductions were made around the room.

SUB-COMMITTEE REPORTS –
Long Term Care – Kristie Knudson *briefly discussed the following:*

- The committee met and discussed: list of services excluded from the contract; long term care services to be included when LTC is rolled in; coordination and how to coordinate transitions with Molina; legal standards of care and whether or not the care tool is the tool that must be used to establish services and service plans for the client; the need to use care for the eligibility in payment determinations for clients, Molina can also do an assessment and it will be a broader assessment most likely with shared planning and the other services that are included in the packet; phasing in of dually eligible individuals and how to give those clients the information needed to make an informed choice about the project.

Mental Health

- The committee met and discussed coordination of care and how to coordinate between the various systems that would be involved and identified areas that need to be looked at more thoroughly: individuals in state hospitals, incarcerated individuals; court ordered individuals with less restrictive alternatives, evaluation treatment centers and determine how the whole crisis piece will work.

Tribal

- The committee met with two tribal representatives and worked on a specific dis-enrollment form to be held by tribal clinics to assist clients with getting out of WMIP.

Education & Enrollment

- The committee discussed provider trainings. Molina, and DSHS are working together on a joint training program. Three dates have been set for October for Molina's provider network and other entities will be trained by HCS and DDD staff. Training packets and a PowerPoint presentation have been prepared.

Research

- Copies of DSHS Response to Selective Comments on WMIP "Report to the Legislature" and DSHS point-by-point response as well as an updated version of the Snohomish County ER Fact sheet were distributed.

David Mancuso stated he "did not attend the last meeting and understood there were comments on the first draft of the Legislative report which has changed significantly." He "didn't want to let some of the criticism in that set of comments go un-rebutted." He stated "The ER fact sheet excluded the general assistance unemployed clients that were in the version distributed in June. Some of the criticisms of Bo's are related to the inclusion of those. although Bo and I had talked at great length a couple of months ago about our having developed a new Snohomish County fact sheet, including the GAU Clients and those numbers would be different. I let him know at that point that we were in the process of preparing a revised version, pulling out the GAU clients and the numbers around them. Part of Bo's comments in the two pages he distributed, there were inexplicable and disputable errors. These are really reflective updates to the numbers

when you exclude the GAU clients and so essentially those were not errors in the original draft legislative report. Those reflect updated numbers excluding GAU clients. A number of Bo's points are really about the aesthetics of presentation and one point that he is focusing on is the emergency room groupings that we used in our presentation. Those groupings are basically entirely appropriate. Often when you have skewed data; data where there are lots of people who have no occurrence of events – no emergency room visits and there are sort of decreasing numbers of extreme occurrences of emergency room visits - you see this when people present information about income; people will use groupings whose width basically changes, as you look at more and more extreme ranges of the outcome. That's what we have done. That's what Bo does. In fact, in his updated presentation he has four categories that he uses in his presentation. One width sort of one; a width of one; two with a width of ten; and one as a catch-all that has a width of 100. So this critique that we use in uneven categories you could also apply to his own re-casting of the material. This is entirely appropriate, it is done all of the time. We are presenting information about skewed outcomes and it is an accurate critique of the way we organize our information. We have been extremely explicit throughout this in the number of clients in each category and the explicit numbers of the evidence in each category. So there is nothing misleading about the presentation. One other thing I would say, is that when we do it his way, clients with co-occurring disorders are really driving the frequent ER visits. That's been a fundamental conclusion, which I think most people have drawn from what we presented and it's a big part of the write-up. This is part of why when we can present for an hour and a half at the Kodiak Conference on co-occurring disorders in Yakima; there are other people we have presented this information to who have recognized that our presentation draws out the important role of the clients with co-occurring disorders have in driving these outcomes. One last thing I want to say.. the rest of what he has written implies the numbers of clients are small, therefore these are less important outcomes than what we're implying. In this county, in 2002, we had in 2002 we had 14th of this population identified with an alcohol or drug disorder, whether alone or a co-occurring disorder. Those 14% of these clients count as half of the overall arrests in this population, and we're talking about over 500 arrests, over 800 arrest charges, and I don't think by any reasonable measure that is a trivial number of clients and a trivial number of arrests. That is an arrest rate, out of all proportion to the broader population or the adult population in general. I don't think that we are over-hyping the meaning of these findings. I think that our presentation is drawing those things out in a way that we hope is clear and I think the general response has been that that is the case. I wanted to circulate these two materials and give you a sense of our take on this."

Discussion followed:

Q:

"When you say that the first one is the substitive one and you say the GAU clients were taken out, were all the GAU clients taken out? Or did you leave in the GAX clients that actually are…..?"

A:

"GAU clients are in. And my understanding is that they are eligible to enroll in this project. And most of those folks are going to be the auto-enroll."

Q:

"And I just wondered, when you said committee is that a committee that includes Bo and …"

A:

"You mean research? There is an internal research group in DSHS that….."

Q:

"Did Bo get a copy of this before we all just got it this morning? He is shaking his head No."

A:

"It's possible I sent it to him as an attachment back in July. It's possible. I don't know for sure. I know that we had a very long conversation and as we talked, there were several points where I told him, my numbers are a little bit different than what you have because I've done a version which includes the GAU clients."

Q:

"My question was mostly directed to David. Bo's already looked at this and had some responses or further dialog on this, I would suggest maybe we could hear that now. But if he hasn't seen it before it doesn't seem fair to ask for any further dialog right now..unless."

Bo

"My only response is…I don't want to belabor this. I think the result that I was hoping for has been achieved; that section has been completed. The report to the Legislature now is that the gathering is very good. The data report that was in the first section and the graphs that were included in it were based on GAU information data in the discussion and then in the text piece, was different data than data that supported the graphs, so the graphs are one set of information and the data reported in the text was not the same information. There were discrepancies like that which is why I say there were inexplicable errors of fact. The facts stated that are part of the basis for the graphs was not the same data that was stated in the discussion in the text. I think it is unfortunate. I don't want to belabor this discussion myself. I'm sure you don't either. I think the effect has been achieved. I was mostly concerned about the data section going forward as justification for this project to the Legislature. I don't think it is a good representation of the research that has been done for this and I think the whole focus of it unfortunately is on emergency room and arrest data and it shouldn't be there. It should be on the needs and services being provided to the other 84% that don't use the emergency rooms any more than twice a year and that I would hope to see dealt with in a much better way in the future in terms of the needs and services that this project is designed to provide."

David

"What is unique about this project: most states have SSI clients in managed care. Most Medicaid Integration projects focus on long term care and medical. What is unique about this project is its relative focus on working with clients who have high rates of mental illness and chemical dependency, and those conditions underlie excessive emergency room use and high arrest rates. And that is a fundamental aspect of the story and a fundamental aspect of the reason we are trying to do this kind of project – so I think it is reasonable to have the data argument for doing a project like this."

NSMHA Report – *Chuck Benjamin*

"As you know, I was supposed to report last month at this meeting, but because of the changes DSHS made in delaying mental health implementation and the Medicaid integration project, plus adding in-patient services back into the project, I had to alter my view of the potential for degradation of services.

The main thing I want to make a point of with the first slide is the fact that we are a five-county region and over the last 10-years the counties have worked very hard in coming together and not looking at county by county specific issues and needs. We actually do look at regional needs, and therefore, we have developed a lot of regional infrastructures and that is what we are really concerned with being impacted. When we say a community mental health, it is all five counties and of course we also push for recovery involving culturally competent services.

I also would be remiss if I did any presentation regarding the North Sound Mental Health Administration and not talk about our vision. Our vision at North Sound is really a vision of hope in paths to recovery for all people suffering from mental illness and we have developed all of our contracts and care standards around recovery. We are also concerned with our ability to

maintain the recovery model with the potential impacts just not from Medicaid Integration, but everything else that is coming at us – which I will get into more detail later.

I also want to make it a point to say that the SNMHA Administration actually does support service integration. I think the issues that we have with the particular model is actually the design of the model. We are already a managed care plan and we felt that the design for the mental health component could have been configured much differently without have any potential for degradation of services on our regional infrastructures. In fact, we did approach DSHS and we had a dialogue and I know we have different perspectives on this, but my perspective is that those dialogues stopped when DSHS said that there would be a carve out to the HMO's and that we would in turn have to negotiate what we could get back from the HMO in services. That is when the NSMHA walked away from the table, because DSHS was not willing to alter their position. It actually integrates, from my perspective, (we hired a consultant to support this); it actually integrating funding. Just the integration of funding in itself does not integrate services. Another concern of our consultant is we are really looking at the clinical integration of the services which we haven't seen yet. I do applaud DSHS recent decision to delay mental health so we can try and work out some of these issues. I'm not sure we will work it out to everyone's satisfaction, but at least it gives us more time to have a dialogue. My concern now is that they are actually going back to the original design that they actually backed out from and that was including inpatient and outpatient. Just as a reminder, when legislative session was in, and we were in Olympia talking to our state elect officials when it included inpatient, the white paper that Dale Jarvis did actually noted that there was 6% of covered lives being moved to the WMIP and between 18-25% of our funding. That raised the eyebrows and concern of a lot of state legislators with so much of the funding being transferred, and our ability to maintain our regional infrastructure. I am just getting a sense, or fear, that we're getting right back into that same position with adding inpatient back in. Again, we'll make every effort to work with Snohomish County, DSHS, and our mental health providers and Molina to have as easy a transition as possible and hopefully that vision of hope. Hopefully minimize any degradation of services.

There are five areas that I would like to concentrate on.

One is the degradation of regional infrastructure. Second is the transfer of critical funding. Third is Adverse Selection. Fourth is the Involuntary Treatment Act and Crisis Line and Emergency Services Risk. The last is external factors that will actually accelerate WMIP's degradation of services in the North Sound.

1. *Regional Infrastructure:*
   The NSMHA manages care for all of its people, which is over one million people, on a very fixed budget. We are a capitated, at-risk, managed care plan. We also pass that risk on to our providers. We have developed a lot of effective and efficient regional crisis services. We have a 1-800 crisis line that is operated by VOA that covers all five counties; we have essential access for all five counties; we have an acute care team for the entire region and some others which I will mention later. But again, these regional infrastructure costs are fixed and we are on a fixed budget. Whenever you take money away, some of these fixed budgets for the regional infrastructures will be impacted. I don't know how we can avoid it.

2. *Transfer of critical funding source:*
   We feel this is really an abandonment of Washington's commitment to a community mental health system of over 30 years, where we have actually as a managed care entity a mix of medical and social services. I'm not saying we are perfect. We all have room

for improvement, but we feel we have been told by Secretary Braddock and others that the North Sound is the best in the state and we are very proud of that, and we are very concerned that the impact that this project would have on our ability to maintain that quality of service. Also increasingly the state has relied on Medicaid 'savings' for our ability to serve the non-Medicaid population and you will see from some graphs and charts in later presentation of why this is such an important component. We do question that there will still be savings with the MIP so where will those savings go on the Medicaid Integration side.

3. *Adverse Selection*
   We are concerned with people we already have in service. We serve 3,700 people out of the 9,800 target population that is targeted for the MIP. We are already serving 37% of this target population and that is costing us $10.4M a year. What we are concerned with is a lot of the people we already have in service will opt out and if that is the case, we will still be serving these people, but we will be losing the funding to serve them (especially since the target population is 6,000, which is 61% of that target population). Even if you ad the people we are already serving and the potential of taking 61%, that is 98% of the target population. It is imperative – who opts in or opts out, and who we already have in service, in that mix. It is very, very critical. The only thing that we've heard to date, that is any fix to that problem, would be retrospective, and that's after the damage is already been done.

4. *Involuntary Treatment Act and Crisis Line and Emergency Services*
   You probably know and probably got tired of me talking about the risk of inpatient care. You know that DSHS has recently made the decision that they are going to move inpatient care back into the MIP. What they are not moving back in, however, for these 6,000 people is Involuntary Treatment Act and Crisis Line Emergency Services. We would still bare the cost of providing those services to the same 6,000 people that would be transferred MIP and we are still concerned with our risk of having to provide these services. A lot will depend on what the actual funding formula turns out to be, and of course, as you've heard before from Chris Emhoff (committee), is working out the coordination of services, since the services are still going to be split. The other thing that we will still run the risk of, unless there is accommodation made is Western State Hospital. We have a bed count of 99 beds. Before, when DSHS was talking about transferring inpatient responsibility to the MIP, they talked about moving a number of beds from our allocation to Molina. The problem with the formula that the MH Division came up with is they based the formula solely on the Medicaid population. When you are talking about crisis services, we are responsible for serving the entire population and if we really look at the mix, the number that WMIP came up with, they should probably get one bed out of our 99 and the MH Division was proposing over 10. I think that's another critical issue. The reason that is such an issue is if we go over our bed allocations at Western in the hospital as a whole; which, by the way, for the past six months they have been well over census; we face a liquidated damage of $500/day for each patient that we're over our capacity. We'll also have a liquidated damage if we are unable to get a patient out of Western State Hospital, when they are determined to be ready for discharge. Those are two different liquidated damages that we could face and that would also, I think that would have some remedies with any contract with Molina.

5. *External Factors*
   We have external factors that would accelerate the impacts of the MIP. One is certainly the new rules that the centers for Medicare and Medicaid services are placing under our system, where we are no longer able to spend Medicaid dollars on the non-Medicaid. I

am hoping the state takes some action against the federal government, because that restriction doesn't hold true for private HMO's. They can use the same as 'any way you want'. Government HMO's can't use the same as 'any way you want'. You'd have to use them on enhanced services that are Medicaid population only. I would certainly hope we could ask for parity from the federal government on that issue. What I don't want to have happen is to have the MIP actually defer our attention away from the CMS issue. That is a looming crisis for the public mental health system in this entire state. It if is a crisis to the entire state, it is also a crisis for North Sound, and added to that we also have the MIP. On top of that we have un-funded federal mandates: the balanced budget act and the quality review that I am happy to say we just went through our external quality review and we did very well. That is another administrative burden along with the balanced budget act. Not just the NSMHA has to face, so does our mental health providers. They are facing those same requirements.

As you know we consulted with Dale Jarvis, who is nationally recognized in health care consultations, and he came up with some areas and I'm really trying to be fair. One is inpatient risk and we talked about inpatient risk. What we talked about with this was that while Molina is responsible for the outpatient then we would still be responsible for the inpatient risk and so the state has gone back to their original design and moved the inpatient risk back over. As I indicated earlier, that really, although it minimizes any risk for inpatient, it still leaves the risk for emergency services, involuntary treatment act, and our 24/7 crisis service line. It also doesn't do anything with the adverse selection. The clinical integration efforts that were outlined in the Jarvis paper – I haven't seen any information on that. The external support is the consultant's report, but also I think what we were looking for, is according to our consultant and I'm not going to get into detail, but he called it the four quadrants where in all of the other MIP's in other states and the designs of them – they really targeted the low, acute mental health and chemical dependency people with high medical needs. That is where they had the greatest savings – by serving that population, who didn't meet the criteria to be served in the public mental health system. Those other states also did not take funding away from the public mental health system because they were serving a different population. I think that is another area of discussion that should continue.

In reconciling the MIP in the CNS and BBA driven, what we are really asking for is for DSHS to really sit back and look at this in a more global picture, and not look at the MIP in tunnel vision. We really have to look at everything impacting us, and some of it I've already mentioned and that's the new Medicaid rules, balanced budget act, and external quality review.

Crisis Services remaining with the NSMHA: 58% of the service hours of crisis services is to the non-Medicaid, leaving 42% for the Medicaid population. NSMHA receives (with the new Medicaid rules we can only use state-only dollars to serve the non-Medicaid) $2.2M of state-only dollars. Our total mandated crisis and hospital costs are just over $11M. Of those $11M, $6.5M are to the non-Medicaid. If you only look at crisis and hospital care for the non-Medicaid, our funding from the state is a shortfall of $3.3M."

Discussion followed;

Q

"This chart reflects without the money being pulled out? This is current? The $3.3M shortfall is the difference between $6.5 and $2.2."

A

"That is correct, and that is to serve the non-Medicaid population. Our only insured is Medicaid and our uninsured is private. We do bill for private insurance for the non-Medicaid, but more times than not, insurance companies don't pay for psychiatric crisis services and they will also

pay for evaluation and treatment centers because they are free standing and not linked to the hospital."

Q

"Do you have those figures? Do you have something that is comparable? Do you have the figures of what has been collected from private insurers of those….."

A

It's extremely low. I can get a number for you, but it's extremely low. We're losing money billing because we don't get the payment. So its really drawing the line."

NSMHA Expenditures

2% NSMHA Administration Costs
6% Administration cost of our Providers – Actual numbers we are reporting to the state in accordance with the state reporting criteria. Total Admin in the region of 8%
5% Clinical Information Systems – We're implementing, along with our providers, a new information system that ties all of our providers into the same system. To hold that to 5% is phenomenal.
2% Quality Management
1% Children's Hospital Alternative Program
9% Evaluation & Treatment Centers: Two 15-bed facilities. We spend 9% of our money on those two evaluation and treatment centers
8% Crisis & Involuntary Treatment Services
3% Crisis Respite
2% 24-Hour Crisis Line (VOA)
6% Residential
42% Outpatient
14% Community Hospital Stays

Impact

"22.7% Across the Board:
Nearly $900K is Administration for is our current funding. There are probably 20 options of how we could try to minimize the impact on this region of a transfer of $11M (approximately) to MIP, that's 22% of our budget. It won't be easy. If we just did an across-the-board, it would devastate – we are only at 8% total Admin in this region to begin with - to cut that any more, or a quality manager and certainly a brand new information system. Children's Hospital Alternative Program. It is very hard to do a partial cut of an evaluation and treatment center, because then you don't have the cost efficiencies of a certain number of beds to offset your costs of operation – so that's not feasible. I guess my point is, to just do a 22.7% across the board, doesn't work".

Maintain Priority Services:

"When the new CMS rules came around, we did some local stakeholder meetings with county coordinators, consumers, advocates, providers and North Sound staff. What we came up with is that the crisis and involuntary treatment services and the 24-hour crisis line are the bare essential services we must provide so that we can assure individual and community safety. Without those two services staying in tact, we cannot do that. So if we hold them harmless and then split the money out across everything else we are still going to have the problem of negatively impacting administration costs, or children's services, residential services, and of course outpatient services. We also worry about our ability to maintain funding to pay for ongoing inpatient stays for the 116,000 lives that remain with the NSMHA. Another thing is just to reduce Admin, E & T and Outpatient. To eliminate an E & T we would have to eliminate an entire facility. That would be a 15-bed facility close and I might add there are only four evaluation and treatment centers in the state currently operating. There is a new one planned for Thurston Mason, but this would be a critical blow to the capacity of this type of service

throughout the state, let alone this region. It is not a decision we would want to make, but it certainly is a decision that we may have to make. We could reduce E & T's outpatient and inpatient only and then we would run the risk of not having enough outpatient funds or inpatient dollars to cover the hospitalizations of the 116,K people we are still responsible for. I also have to add there is the potential of some of that money coming back into our system through a contract to hopefully our current providers. There is about $3.5M of this is for outpatient services and I don't know how much of that could come back and $7.8M for inpatient services and it is not likely that most of that, if any, would come back to the system, because that would be going to pay for community hospital stays of the 6,000 people that would go. There is a potential for some of the $3.5M outpatient dollars to come back into the system perhaps through Compass Health to provide the outpatient services, but we don't know we would get all of it back. Molina has told us that they have a 10% admin rate and I don't know what their profit rate is. Also remember that the state is taking the savings of this entire project off of the top for state savings, so even Molina won't get all of the money that is in the system now. I'm not just talking mental health. I'm talking about all of it. These are the decisions we are going to be having to face. Obviously they aren't good ones."

"Again if you look at what we are recommending, they have deferred implementation of mental health and again we are thankful for that, but now we have other concerns of the inpatient and the potential for more degradation of services because we are going to lose a substantial level of funding. We would still ask DSHS to step back from the plan to transfer capitation revenues from the RSN to the MIP and lets really dialogue about how we can, and I believe we can, how we can actually be successful in implementing a service integration model that does not have to degradate services to the NSMHA and the people that we are serving. We do believe there are savings on the medical side, in fact I've heard DSHS representatives say that that is where they expect to see the savings. They really don't expect to see savings from mental health or chemical dependency. The other concern that we have is that we are already under funded to serve the critically mentally ill and if we are going to lose some funding for the critically mentally ill to build the MIP partnership, will any of that money to used to serve people who fall below the access to care criteria that we have to operate under? We would propose that if that is going to happen, the savings from the medical side be used to serve that target population, not the money that has the potential of being transferred to the mental health side. I have heard from DSHS that they really expect to see a savings come from the medical side and they are transferring money from mental health (I'm just going to use mental health to make it easier). We have the access to care criteria, so people – even if they are Medicaid eligible – doesn't mean they have a medical need for mental health services – and we are under funded to serve that. What I am hearing then is that money that is ear marked originally for the more acutely mentally ill, could potentially be used to serve less acutely ill people, and we are already under funded to serve the acutely."

Q

"Chuck would you just clarify the context of savings? What do you mean by the savings?"

A

"Under managed care, and when the state entered into a managed care contract with the federal government originally, it was understood that if we went into managed care and we provided some efficiencies of care to people, that any left over or savings of Medicaid."

Q

"No, no, that's what I want you to clarify, not that is, my concept. Whatever…an entity provides a certain product that delivers clinical services and what have you, and there is a cost to them. That's the cost. My understanding is that there was that cost and that some how or other the entities, providers and what have you, were able to provide optional services with quote un quote whatever was left over. That's the part that confuses me. I now am going to pretend that

I am a taxpayer saying 'well any good business, if the cost is that, that's all you pay. You don't have savings in that business, if money is not being used then you use that money to create another entity or pay for…..that's a fee for service model……"

A

"Bud I'll still respond to that. First of all I'm going to say, I really don't blame the centers for giving Medicaid or Medicare services saying, you can't use our money to serve the non-Medicaid. We have no profit. And we have no savings. When I say savings, we took money from the Medicaid side and we spent it on services that are non-Medicaid."

Q

"I realize what you did with it, I just saying that somehow or other this is a concept that I think goes counter to any good business way of doing it. If that's all it cost to serve, whether it's fee for service 10 people or capitation or what have you, that's the cost, then the taxpayers should have greater say whether they want to serve more or…."

A

"Well in fact, there is a mental health task force going on that is a legislative governor's mental health task force. They are looking at the issue of the new Medicaid rules. They are looking at the issue of the state not really having enough of the state only dollars in the system to serve the non-Medicaid. I testified at the mental health task force two meetings ago and I am somewhat confident that (this is probably somewhat dangerous) the state legislature will come up with some remedy to the non-Medicaid. What I'm cautious about is will it be a band aid fix, or will it be a real fix."

"I have many questions for him but it will take too much of our time."

REVIEW DSHS DRAFT REPORT OF LEGISLATURE – *Alice Lund*

"I just want to say a couple of things. This is not different from the one that was emailed. I didn't get it down to less than 16 pages. At the bottom of page 7, this is what we talked about at the last meeting, you all asked us to point out that we haven't identified every sing issue but you did want us to bring up the issues that we knew about today. So the referent to the issues is at the bottom of page 7, I just want to let you know how lumped things up and you can look at this list and say 'you absolutely misrepresented our concerns' – that's the thing that would be helpful to get some feedback on. So page 12 has table 2, these are the ones where we went through the list that Janelle had delivered us to go to the implementation committee, the list that was already identified by education and enrollment, and the list that we talked about at the meeting two weeks ago, and we said, 'from our perspective at DSHS, which are the ones that are most critical and we need to deal with the soonest and seem to be of most concern to people in terms of will people be able to figure out how to make decisions and then of course, not having had Chuck's presentation that he just gave, we took a stab at the RSN. This is such a problem but of course there is much more we could answer back now. Table 2 has those three kind of areas of highlighted concerns, and then on the right hand column is what we are doing to try and tackle them as fast as we can, knowing that these are some of the really critical areas. Then we took all the other issues, which of course there is still quite a long list, and they are in Table 3 which is pages 13, 14, and 15, and tried to go through and again, where we had a similar issue that came through all three different venues, we tried to lump them without losing sight of what you all had identified as a specific issue, so we didn't try and lump them so much that the real meat of the issue got buried somehow. Then again in the right hand column we say what the response, why we think that this is a manageable issue as opposed to the ones that area in Table 2, which we feel like, Yah these are things that we know we all need to be working on together. The ones that Table 3 were doing, like, we have a handle on it, we're heading in the right direction, we have ways we think are possible to deal with it, where as the ones in Tale 2 are the ones that we still will be working on in the sub committees – with you all – and looking at

really carefully as opposed to the ones in Table 3. These are either things we're going to monitor and track and you need to hold our feet to the fire on them, but don't rank the same level of, you know, we really need to make sure that we're every single week making progress. So, similarly, if you have things that are on the Table 3 list that you think, you know, gee to me this fits more into the highlight top priority issues, let's hear ….."

Discussion followed:

Q

"First thing I want to say is that on page 14, second clause, I kind of think that ….the real concern I would have, and probably all the providers would have, would be termed as continuity of care. I know that Champus used to have a status of being allowed to have exceptions to the rules based on continuity. The fact is that practitioners often spends hours and hours and hours, and part of his life, investing in relationships with his patients and you can't just generically transfer that over to someone else. I think, however you want to state it, there should be some concern for continuity."

A

"Okay"

Q

"I noticed that in Appendix A, page 11, as an example, in a number of cases you have the word RESOLVED in the right hand boxes. In taking the mental health one, mental health coverage as an example, you have RESOLVED and then a statement there as to I guess the resolution. As I look later in the document though there appears to be areas where it talks about things that have to be done in relation to mental health. The word RESOLVED confuses me."

A

"Okay, calling it ONGOING or IN PROCESS seems more honest to you than saying it is RESOLVED?"

Q

"Yes"

A

"Alright, no problem"

Q

"On the issue of Table 3, page 14, second box from the bottom. Wondering what your department's response is to that line in light of the article that was passed out at the last meeting on the Florida experience".

A

"*Not having actually talked to the people in Florida, it's not clear to me that their model and our model is similar enough that I relate their experience to what the concern is. I think what our plan for it is just as we say, you know, we're going to have tons of data, we're going to track it really closely; we obviously are going to get counter data from Molina that has all the really detailed level of service and experience of the client and similarly you all have asked us to do that for other counties in fee for service and for the clients who are not enrolled and others in that. You know, it's hard for me to say what else we can do that would finish your answer. The question is, will mental health dollars be tracked. And absolutely, mental health dollars are going to be tracked and our response back would be as we see mental health dollars plummeting like a rock, and the same kinds of clients are being enrolled, that's something that we will sit down and take corrective action about."*

Q

"I guess I'm a little confused. Where does this list come from?"

A

"The three sources we took were the meeting that we had the last time, and of course, we didn't have your verbatim minutes yet, so we took all of our minutes that were actually your, probably

ten extra issues that you hadn't even identified on the board, so we took that list, the list that Janelle delivered to the Implementation Committee, and then the third one was the Issues List that had been circulated at this meeting two times ago by the Education and Enrollment sub committee. We took those three and compiled them here."

Q

"It still seems to me like there is a lot of re-stating of the comments I hear coming out of these meetings when they get a question that DSHS would prefer to answer. Like I asked at the meeting last night, what is the impact of this on the patient who is on and off Medicaid. I don't even see that addressed in here. My other question, I don't want to belabor it as Chuck is here today to talk to us about it, is .. you mentioned Chuck's presentation .. do you want to incorporate that into the list of issues that were…or is this just a report as it stands?"

A

"I'm thinking that when we get back today, and of course we have like today and tomorrow to make whatever changes we make before it goes up the food chain, is that those of us here will look at that middle box, the RSN Infrastructure box, and try and figure out how to incorporate the stuff that we got out of today's meeting. So, again, if there is – you can circulate that back and forth really quick in the next couple days and you can take a look at it and see if we captured it or not. The on and off Medicaid I will try and make sure that we get in."

Q

"Alice, do I understand you correctly that we have two days to comment on this?"

A

"Actually, that's why we sent it on Monday afternoon, is because we knew that we were going to have until the end of this week before we could .. our version of the report to OFM the Office of Financial Management, the Governor's office. So we had told you all two meetings ago that we were going to be on a really tight time frame – that's why we sent it.

"What's the deadline?"

The deadline was established at noon.

Q

"*I have to say, I would really like to see Chuck's presentation that weights some things out in an organized way. I think it would be very helpful to see that reflected in this chart, the middle one, the major challenges and what you have to say about that".*

A

"*Alright"*

Q

"I want to take the time to read this more thoroughly, but in browsing it, on page 12, the RSN Infrastructure you talk Actions, and you say there are several other RSN's operate with a smaller client base – They are single counties. They are not multi-counties. We have developed five-county infrastructures that are a of a higher cost than those smaller RSN's are doing in the single counties, and we are also, by the way, the only regional support network in the State of Washington that has committed our out-patient dollars to provide this state with two evaluation and treatment centers. The other evaluation and treatment centers within the State of Washington develop budget provisos with state money only and they get state money only to operate – We don't. So to compare us with even other large RSN's in this manner is totally misrepresented."

Q

"Table 1, the last item, Integrating Mental Health and Long Term Care, I don't see how you can say that is RESOLVED. Clearly, that is something that is ONGOING, a lot of the details of how that integration is going to take place isn't worked out yet".

A
Switch to ONGOING
Q
"*On Page 13, is 'There may be fewer hours of service for long-term care', I thought I heard Bill say today that the care assessment would be a minimum standard?"*
A
"That is correct. I need to reword this."
Q
"First let me say that this is much more readable than the initial draft. So, thank you for that. I do have some serious reservations about some claims made within the document and it would take me far too long today, so I will put those in writing and circulate them via electronically to all members of the committee."
Q
"I'm a Johnny Come Lately on this and I'm trying to get up to speed. I notice one thing in here, a frequent reference, where "this will be monitored, they will be held up to standards, standards will be maintained", and I'm wondering how, if we're going to suddenly have a "woops, that patient didn't get the care and it's too late now" – or whatever, How are we going to make sure. Many of these people who are going to affected are very marginal and how are we going to know ongoing, that this maintenance is kept or is it going to be a sudden unpleasant discovery later when we …. How are we going to monitor them, how are we going to know that these levels are being maintained?
Q
"I would assume that data would be collected in the same way, similarly as it is now, on the number of contacts. I would assume…"
A
"We could put in a whole section that deals with this question. Basically, half of the people working on this project come from quality background and there is stuff that you can do in advance, standards that you can develop in contract language, and then there are ways you can check in advance to make sure the health plan is ready to go before they start enrolling clients. The early alarm systems are client complaints, that kinds of stuff, so you don't have to wait until six months down the road when the data is looked at."
Q
"My concern is that so many of the clients are not the kind of people that complain, or they are afraid to complain and if they are told "no, you can't", they go away and then suffer because of it. They aren't the kind of people that stand up for themselves."
A
That's an important thing to make sure we are clear about in the educational materials.
Q
"A concern some of us have from the whole system is unlike what you are saying, that the provider has a special relationship – too often we have case manager turn over, turn over, turn over, and that the most of the direct interaction is with people that come and go, come and go, come and go. So do we make the comparison between that kind of what I call fragmented care, to better insure more continuity?"
A
"It's certainly something we can talk about either in the evaluation stuff or definitely in here. We've been working with folks from the UW who have a measure for it. So it is something that is pretty easy to track."
Q
"As long as we already brought case managers and internal work, we recently received complaints from case managers that their case loads were too high. So we did a case load review and what we are finding is that the average caseload is 40 – there are some with 60 or

70, but that's okay because we also looked at the acuity of index of illness so they could handle a larger case load – and those were far and few between – only acute case managers had those. At the same time, we also looked at the ___ number rate, and I might be a little off on the numbers and I would be more than glad to make this report available to this entire committee, but as I recall, 40% of the case managers were in service over 15 years, another 20% over 10 years – so basically we have over 60% of our case managers who have been in the system a long time, so they are getting a continuity of care. I'm not going to say there isn't turn over, because there is turnover, but at least through the case load study that we saw, our turnover rate isn't what the national average is – which is very high."

Q

"There are three things. One of them I don't quite see on here, and its something that has really emerged over the committee meetings with long term care and education. We had focused earlier about the disintegrating part of doing integration; there are some things that are getting sliced which creates a need for coordination. What I am seeing in those committees is more and more examples of that as people think through to well, 'what about this group of people that are released from hospitals, are in a special program, we've got so many of those in the region.' I think that there is still this piece of coordination with the other systems, particularly the case management system, HCS, DD, and those. There is a huge coordination piece that we are really JUST getting a handle on what those things are. I don't think that that is resolved. It is something that we're working on."

"The other two are on page 15. And I guess I'd like to see these highlighted more as significant things rather than in Table 3. One of them is about the problems in other states. I think this is a very fair statement. We recognize that Washington is a pioneer in this area and I think the point is this is an untested design. We are not going in with a design that happened in some other place, and we're just tailoring it a little bit here. There is a fair amount of uncertainty that comes from that. This coordinates with some of the things that Chuck put in there, in that we are in a very strange and unique environment and a unique time in terms of the pressures on the mental health. I just think that needs to be highlighted, because it keeps coming up. Every meeting someone comes up with something. Terry Marker came up with a zinger today in the Long Term Care meeting that no body had thought of."

A

"Check this out and see if you think we need to strengthen this. At the top of Page 7 – because part of what people have concerns about is the unknown and the un-knowables, so we have these ..It says, 'Two characteristics are of particular concern to the WMIP Advisory Board. The first bullet is:

- *While pilot projects offer some new approaches, not all impacts can be identified or quantified pre-implementation;*

"Do you think there are two more bullets and a longer statement or put a big…."

Q

"I think you can say that about any virtually every new initiative, but I don't think that gives you any perspective on how radical this is. It's not just radical because we haven't done this in the State of Washington, it's radical in the universe. I don't think that point has really been made. The other thing on page 15 is that next to the last item about the knowledgeable people – and this is coming out the Education Committee. The reality is that everybody has said that the ideal way – when given the vulnerability of this population – really, people ought to have an opportunity for face-to-face, one-on-one with somebody already working with them who has been trained in those areas. We're probably going to be able to arrange that through the provider trainings for some of the DD populations and some of the long term care population – so maybe 10% by using DSHS resources to train the providers and then having the providers

have that hands-on thing. Well that leaves the other 90%. And, even though everybody says this is a very vulnerable population, this ideally needs to happen, we then bracket that and then say, of course there aren't the resources for that so we move on. And yet, the team is doing a great job of working with the resources that they have to say okay, we're going to train the people, we have somebody from DSHS saying well, you know, we get those calls because the people can't get through, this vulnerable population isn't going to get through, so what can we do…….The fact is that there is not going to be the design, the system, and the funding is not there to provide that level of health for people trying to deal with this and I don't think this really highlights the fact that Yes, the department is doing the best that it can with the resources that are allocated to this – but it is clear that it is not enough."

Q

"On page 11, table 1 Rate Structure – you have it RESOLVED. Is there a copy of the proposed rate structures for all these different entities and if not, is it still in process we'll be allowed that information when it comes out? It says RESOLVED and I was confused."

A

"Once the contract is signed and the rates are finished being negotiated. The first round of rates is up there on the website, but the current one we are working on with a few changes has not been posted yet."

Q

"So we are waiting for the new one to come out? When do you foresee that?"

A

"When the contract is signed."

Q

"Will that be released by the next meeting then?"

A

I would….yeah

Q

"Are the tribal concerns to be expressed somewhere, or do they need to be in this packet?"

A

"I think the issues with the tribes are resolved."

"It's not highlighted in bold – if you look at first item on page 11."

"I haven't been to any tribal meetings but I would suggest they should be out and should opt in."

"They are. That's how it's RESOLVED."

Q

"I don't know whether the other issue that I think is a core problem is the current system in which I'm hoping can be addressed in an improved system – this is what we are aiming at, and that is, the reason we have so many individuals in crisis or jail and what have you, is because of the ease with which an enrolled client can be and is terminated. A person doesn't show for an appointment or the person is given….How is that addressed? How is the basic problem relative to this population that is most damaged by the flaws in the system – how do we address the ease with which individuals are terminated."

A

"Probably DSHS?"

Q

"The provider. I'm the provider and this person doesn't show up and then I compensating and I have no idea what the rules are and so then I'm just terminated….that's the core problem as to why we have to fix it…I don't know where that's addressed in here."

A
"That can be addressed."
Q
"On the back you have timelines, Tasks and you've got Health Care Network in place by December 31st? Is that … I thought the original plan was to have it in place before the contract was signed."
A
"It's put sort of like a drop-dead actually, but we, there is a check in our system that, before, well, I wouldn't say before the contract is signed, but there is a pre-enrollment start check in the system to make sure that the provider network is adequate and I don't actually have a date on the top of my head ……"

"It's September 15th."

Q
"I thought DSHS said the contract wouldn't be signed until after there was news that an appropriate network in place."
A
"Part of the point is too, there will be additional providers added to whatever – assuring there is adequacy at the point the contract is signed, but we also expect to see signature before additional providers will get added. on."
Q
"I just want to point out that that adds another dimension of complexity for people deciding whether to opt in or opt out. When they look at this in November and there will be different information than there will be in December – and of course, the single most significant factor for them is are they going to have access to the provider they want."
Q
"And on page 14 of your report, in those boxes, on Table 3 you claim that when WMIP will not enroll clients until the provider networks are in place so….either they are in place or they are not".
A
"Well, but having the adequate network and a final network are two different things. We will make the determination if there are enough providers to start signing up clients."
Q
"At this point, I have very little say over whether or not a psychiatrist takes another job or the case manager or the program is shifted because of lack of funds and what have you….I don't have much choice over that, so if I'm that person, it looks to me as if I'm being provided more opportunity, is this correct? I just want to be sure"
A
"Are you talking about just in the mental health?"
Q
"Mental Health, Yes."
A
"If you are being provided with a different set of choices that might include your current system….."
Q
"Well, but currently, I have no choice. Currently I am enrolled….because I can't….lets just say you get a job in Oklahoma and you leave, I have no choice, I want you and you are going to Oklahoma and I can't have you any more…currently that's the …..you are shaking your head No."

A
"No."
Q
"So I currently don't have any of these choices. I'm just trying to think in terms of, if I'm trying to explain this to somebody….this is what we now have, this is what we will have…and I want to be sure that I am clear on that."
A
"I think the tricky part is that you have to explain to them not just what happens in the mental health but you also have to explain what happens with their medical side also."
Q
"Are we tracking mortality as well?"
A
"Heads nodding. You are on record as absolutely."

Client Education and Client Enrollment – *Becky*
"A brief update of the committee. We did have our very first focus group yesterday where we tested the preliminary and draft enrollment information – I'm calling it an enrollment guide – we've contacted 8 clients and we had two show up, so we were feeling quite accomplished. It was a very interesting session. I sent a copy of the interview questions that we asked and a copy of the enrollment guide to the E & E sub-committee so those of you on the committee have seen them and I will pass them on to you Janelle, so that you can pass them on to the Community Group. Since we do have three more focus groups scheduled; we have two scheduled for the 13th of this month and one more scheduled for the 14th of this month, our drop-dead date to get this publication is the 16th so I have to have all comments in by the 15th so I can take it up to publications and sit down and discuss exactly where the page layout has to be and what this looks like and this is a time line that flows into an entire DSHS process of translation in getting it to Department printers. So while the clients will receive this information on November 1st it pushes it way back to the September 15th date when I have to get it to publications. "

"We did talk a little bit about some of the content of the enrollment guide as people were still not happy with the level of information that is being given to the clients concerning the long term care and the mental health phase in that was what I would call a health discussion. At this point, after talking to two clients, I have no problem with adding a couple more pages to this enrollment guide. It was originally 27 pages long and is now 18 and when I asked the question at the end of the session, 'Do you feel that this information is too much, too little, or about right", it was about right. They felt that they would read it. They felt that they would read it; there were a few things they suggested we even add, and they did not want to see this in piece-meal. They wanted to see the information come to them all at once so that they would have it handy as a guide. DSHS has long been contemplating the idea of sending important information and then if you want more, ask for it and we will send it to you, but our two clients indicated they would like to have it at the same time and then just hang on to it."
……
"Basically I think you are talking about the mental health performance….Our understanding is that those information sources aren't going to give us the sort of population based pre/post type of data that we …noise interference…….We are doing a whole range of outcomes related to mental health so we think ……..other outcomes, health outcomes, mortality outcomes, from people who are in the project now, …… who have mental health treatment. We are covering a lot of ground in mental health, but those systems ……on the evaluation side."

"Two items on the back of the page we needed clarification from you on:

Tracking discharge outcomes including completed treatment, opted out, discontinued services, moved out of county, etc… and I don't know is that chemical dependency tracking?"

"I think it was a general of clients enrolled – how are you going to track them if they…"

"Completed treatment…"

"Where does this come from?"

The second:
"The numbers of people with high-risk factors attending science-based prevention programs?"

"I think that one came from Jim Teverbaugh."

"What happens after this?"
"We thought these were just questions that you had for us regarding the evaluation design – would we be including these items or could we, and the answer is yes. Look for the final evaluation design to incorporate these items."

"On the issue of Telesage. Were you saying that you can't have pre and post implementation – well not everybody that gets transferred into WMIP will automatically be in service or already in service. The Telesage is an assessment tool which you do at intake and then there is some frequency of time, I think it might three or six months, so the case managers don't pre-impose implementation information available as also incorrect."

"I think what I said was that the population for example, those experiencing mental illness would not currently be achieved, but prior to their enrollment there is no history for them in Telesage so we won't be able to track……"

"But you will be able to track the change from the time they come into the system, which is what the Mental Health Division is requiring us to do. "

"So are you asking for parity?"

"Yes."

"I think for us it's a matter of what should we measure in the integrated system."

"You're not concerned with the same mental health outcomes that the public mental health system is concerned with?"

"Well, as David said, there is actually a lot of overlap in the outcomes for the integrated system we just don't want to…….. so much an evaluation when we tried to look at outcomes including mental health outcomes…."

"But frankly, I keep hearing that we are going to compare and if you aren't comparing using the same tools in your comparison and the same information, you're not going to be able to compare."

"We are using exactly the same tools. :

"You're not even doing it…"

"We will not be using, I would say a measure to do outcomes for the project for this evaluation we will be using a wide range of other information."

"Well then let me say this in a different way. Here is another administrative burden that DSHS is placing on the RSN, that we are going to have to pay for, the providers are going to have to use more resources to provide the Telesage work and again, I'm looking for parity."

Janelle Sgrignoli:
"We would like to propose a report coming from this committee to – also to the Legislative Committee…We've talked several times about a minority report, so what we did, and Mike Manley has a draft copy, we would like to submit to this committee for review and ask for your feedback and your concurrence whether or not you would like to submit a minority report to the Legislative Committee."

Mike Manley
"As Janelle said, the Legislative Committee, the House Appropriations Committee are reviewing this project probably on the 20th or 21st or thereabouts of this month. The report that Alice provided to you is the state's report; this would be coming from this advisory body. The report you are now receiving would be coming from this advisory body. So it is written with that presentation in mind. It has been through a number of drafts; a number of people have commented on various reiterations of the draft; it's in three sections; there is a background which is a historical kind of contextual description of the project. There is vocal concerns which is simply set as bullet statements that try to state succinctly what concerns the committee has aired and have yet to be fully resolved. Then, finally, there is a conclusion statement. We still consider this to be draft stage. What I would like to propose is that by close of business on September 9th, you get to me your comments on this draft if you have suggestions for changes. If you have suggestions for changes, it is a lot better if you send me your proposed text. Not just general ideas. Your comments will be incorporated as best we can and then we will hopefully be sending the final draft out to voting members of this advisory body – electronically and standard mail – and will ask you to vote up or down on the entire package on this report. If we receive a 'yes' consensus that the draft is okay, it will be presented to the Legislative Committee. If not, we'll go back to the drawing board."

Janelle Sgrignoli
"We want approval by this committee to go forward with this prior to editing so you can finish that……"

Q
"The Legislative directive was for DSHS to report back to the committee after meeting with….blah, blah, blah. Now, this could go to, whatever the comments are, could go to DSHS as the committee's response to DSHS with a request for them to incorporate this, or it could go directly to the Legislature, and it looks to me, like what the proposal is that this would be something that would be presented to the Legislature rather than to them and is part of the reason for that the timing issue here, that they have to get their report run up the flag pole before this deadline for finalizing the issue?"

Janelle Sgrignoli:
That's part of it and then there's the other piece was that there was some disagreement about how things were being presented in the draft reports and disagreement, so to make sure that that minority voice got heard that there were concerns at this table that be taken up on.

Mike Manley
We all recognize that we are in a long process somewhat truncated by the timelines for implementing this project. There are many issues that need to be resolved and the purpose of

this report is to highlight what we consider being the most important unresolved issues to take care of as we implement this project. It's keeping these on the radar screen.

Steve Ahern moved the committee proceed with the document. Marie Jubie seconded.

Discussion followed.
Q
"Is the county itself going to submit?"
A
"No. The county will not."
Q
"So this would be the Snohomish County Advisory Committee submitting this document?"
A
"Correct."
Q
"Is the state going to make comments on this or not?"
A
"I would ask the board"

"The answer is No."

"I think we are past the point of getting into diatribes so if there is information that would be helpful, I would like to hear them."

"This is a perception report. What is most stark to me is difference in perception of where we are towards resolution and on a number of basic issues, and the goal of this report is to represent the perception of this advisory board, where we are in relation to achieving the goals that we all understand to be the core purposes of the WMIP and doing so in a way that is beneficial to the clients we are supposed to serve. "

Randall
"*Would passage of this motion by this committee eliminate the possibility of a supplemental comment report by constituent organizations?*"

"No. "

"So, for example, if my organization, our union – Homecare Workers – could say we agree with the report, but we have a supplemental…"

"Easily, and they could do the same thing with the state's report. They could say we agree with things in the state's report, but we have a supplemental. "

Steve
"The only comment about the state commenting on this is it appears we should allow them to comment at least on factual".

Janelle Sgrignoli:
"*Yes And that is some of the things I've gone through, is like "well, no this isn't quite accurate. Yes.*"

Members voted on the motion: All were in favor; two abstentions (Eleanor Owen and Ann Vining); and the motion carried.

Members agreed to vote electronically, a final report would be compiled and the week of September 13th members would receive an e mail with yes/no boxes for voting.

Q
"When the report is sent to the Legislature, will the committee members be listed by name? And if so, will it be voting members versus non voting members?"
A
"Yes".

ANNOUNCEMENTS
Steve Ahern announced a Candidate's Reception, sponsored by the Council on Aging and Long Term Care was scheduled for 1:30 at the Everett Station and all members were invited to attend.

Meeting Minutes:
Steve Ahern moved the minutes be accepted as written; Marie Jubie seconded, and the motion carried.

Public Comment:
"It seems to me that if we didn't have this million dollars, or whatever it is, taken out of the budget to deal with this, we wouldn't have all the pressure to do it on a timeline that is creating all of these concerns, and we wouldn't have to be pulling out, in order to make a rate work, pulling out money out of a place that it seems ill prepared to deal with that loss. Concerns not only for this population, but as a resident of the county and region, it is a concern for all sorts of issues: jails, crisis for everybody, etc."

"Can you forward to the group the legislative content and where this is going to go. If this report goes you are going to send it to……"

"We will send it to the House Appropriations and also to all of Snohomish County's delegation and probably should send it to the other four county's delegations."

"I would just like to ask if their constituent groups like SEIU or Compass, have other comments…just as a courtesy, I would be interested in seeing your comments and I'm sure the committee would be also".

The House Appropriations Committee meeting date information will be sent to Janelle.

October 7, 2004 Agenda
Updates on Olympia
Sub committee reports
Medical Network Update
Funding – DSHS asking for additional funding?

Public meeting on Friday, September 10, 2004 at the PUD Auditorium

ADJOURNMENT
The meeting adjourned at 12:35PM.